NOVEMBER 1955

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Mental Hospitals

Volume 6
Number 11

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Regular Features & News

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(Cover design by Henry D. Chaplin)

THIS MONTH'S COVER

The November issue is always recognizable by the cover picture of the winners receiving the Annual Achievement Awards from the Medical Director. This year Dr. Frank Adelman of Western State Hospital, Fort Supply, Okla., is shown receiving the Award plaque from Dr. Blain. Holding their Honorable Mention certificates are Dr. Robert Wyers, Supt. of Metropolitan State Hospital, Calif., (left), Dr. John T. Shea, on behalf of Boston State Hospital, (third from left), and Mr. Alfred Sasser, Jr., Supt. of Muscatatuck State School, Ind., (right). Oklahoma's Commissioner, Dr. Hayden Donahue (third from right), was invited to join this group of deserving people because this is the sixth year a hospital under his direction has won Award honors.

Four hundred and sixteen people, including staff, attended the Seventh Mental Hospital Institute in Washington, D. C. Of these, 242 were pyschiatrists; 69 were business administrators on a state or hospital level; 89 came from other hospital disciplines and from related agencies.

The only prepared paper, the Academic Lecture, was by Dr. Jerome Frank of Johns Hopkins, Baltimore, on "Group Psychotherapy."

The first day was devoted to aspects of the growing trend towards greater patient freedom. It was interesting to note that "patient freedom" in these discussions was not conceived to be merely the lack of restraints, but a much more positive and constructive type of psychological freedom which, hopefully, will prepare the patient for better adjustment in the community after his discharge.

President R. Finley Gayle, Jr., spoke after dinner on the place of the psychiatric units of general hospitals for the immediate care of the acutely ill. The problems of the relationship of these units to total community welfare, private psychiatric hospitals and the state hospitals are great, and all concerned must work together so that a solution may be found.

The optional programs on Wednesday afternoon and evening consisted of a tour of the Clinical Center, National Institute of Mental Health, another of Chestnut Lodge, where luncheon was served to nearly 100 visitors, and of St. Elizabeths Hospital. The high spot of these programs was the patients' performance of "Cry of Humanity" at Hitchcock Hall, St. Elizabeths Hospital. The professional hospital audience, more than two hundred strong, was deeply moved. The professional skill of the producer, Marian Chace, and the utter identification of the patient-players with their roles brought audience and players together to share a theatrical and human experience which any professional performers might envy.

The Proceedings will be published somewhat earlier than usual this year and in a different form. One complete issue of MENTAL HOSPITALS, greatly enlarged, will be given over to substantive accounts of the discussions.

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The Mental Hospital Institute – An Appraisal

By DANIEL BLAIN, M.D., Medical Director, American Psychiatric Association

THE SEVENTH Mental Hospital Institute has just closed. Four hundred people—not counting staff members—crowded into the meeting room for twelve plenary sessions, and vied with one another for the attention of the Chairman. Discussions developed, gave place to new debates, and were picked up and continued in the lunch room, in the hotel lobby and during the evenings. The identical spirit, the same enthusiasm, the same spontaneous participation animated this large group as in Philadelphia, nearly seven years ago, when a group only one-third the size met together for the first time to discuss hospital problems.

What events led up to this meeting, so obviously different from the usual conferences?

Hospital Needs Great

By 1948, the American Psychiatric Association, venerable in its 104th year, had undergone a minor revolution with the return, from World War II, of psychiatry's leaders. It had increased its dues, and in the spring of that year had appointed a full-time Medical Director to give administrative leadership and stimulate its programs.

A continuous trend was being felt in the direction of increasing interest in mental hospitals. The Veterans Administration hospital and training programs had been showing the way since 1945. In the fields of nursing, social service and clinical psychology there was growing recognition of mental hospital needs. The voice of public opinion, sparked by newspaper and magazine articles, was beginning to be heard in the land.

The A.P.A. had inaugurated a plan for the inspection and rating of mental hospitals in September of that year, under an able and experienced Chief Inspector, Dr. Ralph Chambers. For six years, the Nursing Consultant of the Association had been assisting in nursing and nursing education problems and was earnestly pleading for improved educational programs to better enable nursing schools to meet the requirements for A.P.A. approval. A Mental Hospital Section of the Annual Meeting was being discussed and was finally established at Montreal in May 1949. The A.P.A. Committee on Psychiatric Standards and Policies had in 1945 and '46 published standards for mental hospitals and out-patient clinics. Standards for other facilities were in course of preparations.

Still something more was needed. The mental hospitals were overshadowed by the vast expansion of the private practice of psychiatry. Yet in the hospitals lay the major needs for professional personnel – physicians, nurses and other disciplines—and new techniques of treatment and administration. Public hospitals were scattered, lonely, neglected, forgotten, and cursed by a burden, inherited from the unproductive past, of uncured thousands of patients.

In the years immediately preceding, the new Medical Director had visited, along with other officers of the Association, hundreds of hospitals all over the U.S. and Canada, and had been profoundly interested, not only in the problems the hospitals faced, but in the many good things which were being done in spite of the difficulties. He was especially impressed by the geographical, intellectual and professional isolation of the people who were trying to treat the patients.

On December 1948, this new administrator whose job description was unwritten and who was therefore more free than any other individual to follow any lead which appeared, said to Mr. Robert L. Robinson:

"Something more must be done for hospital leaders. Why not have a meeting just for hospital staff people and let them talk and talk and talk to each other and to the psychiatric leaders of the day?"

He agreed. We telephoned President William C. Menninger, who always dared to try something new.

Everyone was busy, he reminded us, but—

"Go ahead if you think you can do it."

The First Institute

On January 15, 1949, the Executive Committee formally approved the idea. The place of the meeting was to be the Institute of Pennsylvania Hospital, the birthplace of the A.P.A. in 1844. It had to be held before the Annual Meeting in May or else wait until Fall—unthinkable in the face of our enthusiasm. Now was the hour to try something unique, to really meet the needs of the hospitals. April 11-15th was fixed as the time.

The imperatives of the plan were many: it must offer a forum for free discussion among all hospital people; it had to be self-supporting; the number should be limited so that everyone could join in; since the patient was affected by everything that happens in the hospital, every staff member should be informed about all activities, programs and publications—hence the decision to have one topic discussed at a time, in one big room.

The sum of $50 was finally decided upon as a "tuition fee," to cover costs of travel for leaders and staff and the publication of the proceedings—a copy for each delegate. Banquet and lunches were included in the fee to keep the group together and to maintain and develop its homogeneous nature. To make this tuition fee worthwhile, everyone had to work hard. Planned socializing was limited to a cocktail hour and a dinner on the first night, so that we could all become acquainted early in the meeting.

A super-intensive personal promotion campaign finally brought 145 people to the meeting. A further 45 faculty members, speakers, guests, consultants and staff brought the total to 190.

Four overall topics were discussed—Administration, Personnel, Community Relationships and Clinical Relationships. The sessions were started on time and the now well-known "Institute Bell" was rung before each meeting. They finished on time as well, no matter how interesting the discussion, so that the next fellow could have his chance.

The great leaders of the day took part as discussion leaders and consultants—Drs. Overholser, Tarumianz, Terhune, Barton, Bowman, Noyes, Nielsen, Hamilton, George S. and George H. Stevenson and many others. The Committee on Psychiatric Standards and Policies, of which Dr. Mesrop A. Tarumianz was Chairman, and the Local Arrangements Group under the leadership of Dr. Kenneth Appel, worked actively in helping to plan and operate the meeting.

The result was a tremendous talkfest! It was the first time hospital people had ever had the chance to get together and talk over their problems, pass on their ideas and try mutually to find solutions.

Important Movements Initiated

The plan had arisen out of the needs of the time. Today it still seems to meet the needs, since the character of the Institute has undergone but little change in seven years. It is still unicameral, except for two hours of simultaneous sessions in which we test out topics which may be discussed in plenary session the following year. It is still spontaneous, providing for the expression of unrehearsed opinion, questions and disagreement. The Medical Director rarely speaks from the floor, though often nearly overcome by his need to do so!

The Academic Lecture is a later addition and is always outstanding. The percentage of non-medical delegates has, however, increased from 10% to nearly 40% and this is entirely in keeping with our earliest hopes of encouraging all disciplines to learn from one another and about one another's aims and difficulties.

Many important developments in hospital psychiatry had the Institute as their initial forum. Dr. Appel first broached the subject of "a Flexner Report" on mental hospitals at the Institute at Little Rock, Arkansas, in 1953. This has led to the passage of Public Law No. 182 (84th Congress), appropriating a million and a quarter dollars for a national survey, and the formation of the Joint Committee on Mental Illness and Health. The certification of mental hospital administrators was first discussed at the 1952 Institute in Columbus and the current wave of demands for better administrative training for physicians in charge of mental hospitals has been developed by repeated discussion.

Value to Staff Members

Out of the first Institute grew the A.P.A. Mental Hospital Service, which was supported for its first two years by the Commonwealth Fund and thereafter became self-supporting. The Service through its magazine, MENTAL HOSPITALS, special mailings and other publications, fills the need for direct communication not only between hospital psychiatrists, but also between the rank and the file of hospital staff members.

The Institutes have supplied material to the Council of State Governments for its publications, and have also added impetus to the development of increased services to mental hospitals by the Association. (Such services now number ten—the Committee on Standards and Policies of Hospitals and Clinics, the inspection and rating service of the Central Inspection Board, the Mental Hospital Service, the Institutes themselves, the certification of hospital administrators, the training of psychiatrists, nurse and psychiatric aide training in hospitals, the Committee on Nomenclature and Statistics, the mental hospital architecture study and the state surveys.)

Out of the Institutes, moreover, develops the material for the Mental Hospital Service during the coming year. Ideas for articles in MENTAL HOSPITALS, for special mailings, loan library and other publications come not only from our Consultants and Contributing Editors, but also out of personal discussions with delegates during the Institute. Staff members of the Service say that the Institute is their most fruitful source of ideas, material and stimulation. Limitations of staff and budget prevent as many visits to hospitals as would be desirable and the Institute therefore affords the best opportunity for staff to meet the very people for whom they are working.

Present Problems and Future Plans

Nonetheless, certain problems are always with us, many growing out of the very nature of the Institute. Although the vast majority still prefer the free discussions during which each makes his contribution to a growing body of knowledge, some people come hoping to be told what to do. Good discussion leaders who can encourage productive participation are hard to find, and the formulation of the topic by the chairman is not always successful. Some important topics are unfamiliar to the group, and so discussion lags.

Discussions frequently stray from the topic, but this is not always bad. Occasionally such deviations reveal the true interests and needs of the group. In a meeting which allows everybody to talk, some will obviously make remarks of less significance than others. Again, any attempt to rule out contributions from a few who tend to "monopolize" discussion would result in a loss of spontaneity, as well as of valuable material and ideas.

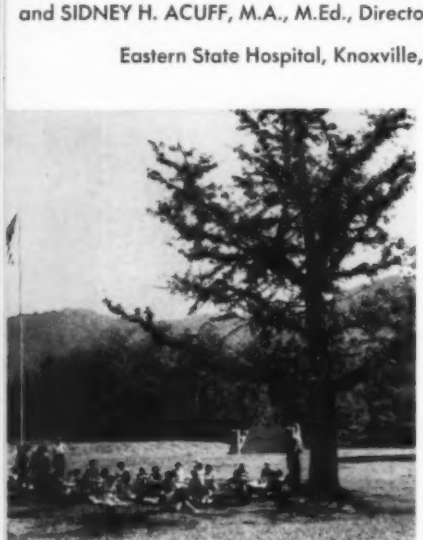
The planning of the Institute's program is done by relatively few, but they make every effort to meet the needs and desires of the entire group. The questionnaires, distributed at the end of each Institute, are carefully tabulated and form the basis for the work of the Program Committee of the coming Institute.

The Institutes afford the Medical Director, as well as his staff, invaluable professional liaison with hospital leaders all over the country, leading to a greater awareness of their needs. This results in the development of new methods, ideas and services. Our next step forward, therefore, will be better-organized collections of factual and statistical material on a nation-wide scale for distribution at regular intervals.

The Proceedings of previous Mental Hospital Institutes have been made available in a "special package" of six books for $9.00 or any three for $5.00.

An Experiment in Living

By B. F. PETERSON. M.D., Superintendent
and SIDNEY H. ACUFF, M.A., M.Ed., Director, Adjunctive Therapy
Eastern State Hospital, Knoxville, Tennessee



The shade of the big ginko tree was always a favorite resting spot for those with a few spare minutes to loaf.

Archery, though new to most patients, quickly caught on and brought much satisfaction to those who mastered the art.

Impromptu song fests were a common thing and seemed to demonstrate the high spirits of the patients.

THE STAFF at Eastern State Hospital, Knoxville, Tennessee, realized that, as a result of the new drugs being used in our hospital, many chronic, long term patients would be improved to the extent that they could be returned to their home communities. It had been our experience that some of these long term patients, on discharge, had not been able to adjust to the home life situation after such long periods in the institution. Thus the Superintendent conceived the idea of setting up a "therapeutic community project" which could place the patient in an environment freer than the confining atmosphere of the hospital yet still providing some of its security. The new environment was to provide a transition period between hospital and home.

With this thought in mind the following program was set up. A local Y.M.C.A. Camp was rented for a three weeks' period. The camp, located in the Smoky Mountains, had living and dining room facilities for 100 people, as well as a swimming pool, lake, shelter house, and sports area. Male and female cabins were at opposite ends of the camp, with five cabins in each area. Eight patients and one aide occupied each cabin. A total of one hundred and fourteen patients participated in the project, most of whom were diagnosed as schizophrenic. On the staff were twelve aides, one registered nurse, one occupational therapy aide, four graduate assistants from the University of Tennessee as recreational workers, one life guard, one truck driver and two cooks, headed by the Director of Adjunctive Therapy.

It was felt that, to make the program successful, we had to remove, as far as possible, the authoritarian atmosphere and other evidence of hospital routine and restriction. This was accomplished to a great extent by eliminating all employee uniforms, having patients and employees eat together, and share sleeping quarters and other camp facilities. The elimination of this patient-employee hierarchy was a great morale builder.

Food and clothing also played an important part in this "therapeutic community project." Meals were served "family style," almost on a resort basis, ranging in scope from shrimp to steak. Women wore various colored slacks and blouses, while men wore sport shirts and slacks. There was no resemblance to the clothes worn at the hospital.

Free Choice of Activities

In planning the daily activity program the guiding principle was freedom of choice. Thus, although the patient was required to join some group, he was free to choose that activity which best suited his interest and ability. The necessity for constant supervision of coeducational activities was met by requiring that patients go to and from all activities in groups accompanied by aides who had chosen that particular activity and were simply part of the crowd. By having everyone assemble as one large group before activity periods, patients fell in naturally and easily with their interest group, and were spared the all too common feeling of herding or regimentation found in the hospital setting.

The daily schedule was outlined as follows: Mornings were devoted to "classes" in archery, folk and square dancing, nature study, swimming, folk songs, and a camp-improvement project group. Although patients were allowed to change classes, they were encouraged to remain with the same class for at least a week so that some development of the new skill could occur.

Afternoon activities stressed informality and included swimming, fishing, boating, hiking, and camp area activities such as softball, horseshoe or shuffleboard tournaments, or just free time to spend in the canteen.

Evening programs provided for a different activity each night but always ended with a much-demanded dance period. Song fests, game nights, cookouts, stunt and skit nights, council ring fires, and Sunday vespers led by the hospital chaplain were among the evening activities. Although 10:00 P.M. was taps, at times there was difficulty in closing evening activity because of the great interest shown.

A typical day, starting with reveille at 7:15 a.m. might run: KP, assembly for Flag Raising and medications, breakfast, area and cabin clean-up, morning classes, return to cabins, medications, lunch, cabin rest period, afternoon activities, women's bath period, men's bath period, KP, Flag Lowering, medications, supper, evening program, ending at 10 p.m. with Taps.

Freedom Accepted Gradually

Many unexpected problems arose during the course of the project. For example, two patients became so tense that it it was necessary to return them to the hospital on the second day, because of their inability to accept the lack of security that was provided by normal hospital routine. Other patients seemed faced with this same problem to greater or lesser degrees but after the patients were able to accept the lack of window-guards, locks, and greatly increased freedom, there was a considerable relaxing of the tension that was first noticed. There began to be, day by day, improvement and greater participation in normal community activities such as were provided by the project.

The majority of the patients were on either Reserpine or Chlorpromazine, the average dosage of Reserpine being 4 milligrams per day, and the average dosage of Chlorpromazine being 400 milligrams per day . Experimentally, one paranoid per week was included and it was found that about a week was all they could remain without arousing too many conflicts in the community.

In the group were several patients who had been in the hospital for more than twenty years. The average hospital stay of those in the project, however, was four years and one month. Those project patients who have already returned home are, from all reports, apparently making a good adjustment. It is felt that the hospital will be able to return to their homes and communities over forty of the patients who were involved. One of those who have gone home was a female patient who had been ill a total of twenty-one years, and had, until July 1955, required tube feeding for many months. She made an excellent adjustment in the project community and was participating voluntarily with some initiative during the latter half of her three weeks' stay.

From our community project we have developed a new concept with regard to our treatment program leading to return of the patient to his home. We plan to develop a year-round therapeutic community for patients approaching discharge. This project will be totally detached from our present hospital operation. By providing this transitional, informal, non-hospital setting, we feel that we will be able to return our patients to their communities with a far better chance for adjustment.

Editorial Note on Hindsight and Foresight

This apparently unseasonal feature is published in full awareness that most of our readers are currently concerned with Christmas programs. But Dr. Petersen tells us that his own planning period, which started last winter, was all too short. The moral, as well as our intent, is, we trust, apparent!

Photos 1, 2, 4, and 6 by Hugh Lunsford, Knoxville Journal

Project Director Acuff calls the turn to a Virginia reel. Dancing was the most popular activity.

Red Cross Water Safety Instructor demonstrates how not to fall out of a boat.

Lifeguard keeps watchful eye as some swim, others just splash.

Hospital Psychiatry in Norway

By PROFESSOR ORNULV ODEGARD, M.D.
Medical Director, Gaustad Sykehus, Vinderen, Oslo.

IN NORWAY, as in all other countries, the long-term public mental hospitals constitute the nucleus of hospital psychiatry. Our twenty public and two private hospitals have a total of 6600 beds, but overcrowding has made it possible somehow to accommodate nearly 9000 patients. The number of mentally ill persons under public care is 17,000 (out of a total population of 3,359,000) which means that half of the patients have to be cared for outside of hospitals. While the bed shortage necessitates this, the fairly old tradition of family care for mental patients makes it possible. Most of these patients are placed in families on small or medium size farms, two to eight in each place, and under the supervision of the district public health officer.

If a mental hospital is conveniently located, it may have its own family care, which is regarded as the preferable system. Larger nursing homes, private or owned by local authorities, are on the whole less common, but are on the increase. In itself the system of family care is not only cheap (the cost is one third of hospital care) but even satisfactory, provided suitable patients are selected—relatively well-preserved chronics in good physical condition who can do some work. Unfortunately, overcrowding has forced the hospitals to board out even disturbed and unclean nursing cases, and this has to some extent brought the entire system into disrepute.

As a consequence of this extensive extra-mural care, the patients in a Norwegian mental hospital will differ from those of most other countries: the quiet and well-behaved chronics are to a large extent missing, and the concentration of disturbed and difficult cases is much higher. Thus there is less need for open wards, and the cottage system is not much in use.

The typical Norwegian mental hospital has 350 beds (only two have 600 or more.) In the older types all wards are closely built around a central square or along a longitudinal axis. In more recent ones, buildings of 60 to 120 beds are scattered in open, park-like grounds. In addition many hospitals have two to four open cottages for convalescents or well-behaved chronics who, for some reason or other, are not suitable for family care.

The buildings are frequently old, and the average mental hospital is not in very good repair. Modernization of old buildings has in some instances proved very successful—for instance the 100 year old Gaustad, which was built along a longitudinal axis. The closed squares represent much more difficult architectural problems. Our main advantage is the moderate size of the mental hospitals, and it is felt that even in the future no hospital should exceed 700 beds. This type of hospital is well suited for a division between two chief physicians each of whom will just be able to maintain a personal contact with his 350 patients. The additional medical staff should consist of one senior psychiatrist and three assistants, but some hospitals are not quite up to this standard. The chief medical officer (or in a divided hospital, one of the two) is even the administrator of the entire hospital.

Use of Ancillary Skills

So far only three mental hospitals have full-time psychologists. Social workers are coming into use but owing to the great distances and the predominance of rural districts and small towns, the hospitals mostly have to contact the local public health system for such assistance. It is also felt that it may be a mistake to relieve the hospital doctors entirely of their responsibility for the social history of the case and contact with relatives.

The proportion of nursing staff to the number of patients is one to four, (*number of shifts is not mentioned—Ed.*) but not many of these are fully trained nurses (three years nursing school in a general hospital, including three months psychiatric service). Most male and many female nurses have merely one or at most two years training at a mental hospital, and it has proved difficult to arrange for these pupils to get a training period in a general hospital (At Gaustad they are since last year getting six months). "Nurses' aides" are not known, but a small number of maids are employed to help with the cleaning, mostly outside of the sick wards.

Occupational and recreational therapists in the American sense of the word are hardly found. The leaders of occupational therapy are generally experienced nurses who are picked out for their interest in this particular field, and who are getting some additional, but unsystematic, training in arts and crafts. One reason why this system seems to work satisfactorily is that the principal aim is to get every patient into some kind of occupation, with emphasis upon the difficult and deteriorated chronics. In spite of the difficult clientele a daily average of 60 to 65 per cent of the patients in our mental hospitals are doing some kind of useful work.

All mental hospitals are allowed to take voluntary patients, but the need for this form of admission is not as great as in countries that have a system of legal commitment, which is not known in Norway. Non-psychotic patients—psychopaths, drug addicts and neurotics—are admitted as voluntary patients, but owing to the shortage of beds, few mental hospitals are able to receive any great number of such cases.

Some psychiatrists feel that the mental hospital should be the sole psychiatric hospital in a district. Special wards would then have to be reserved for non-psychotic cases. This is a solution which may be simple and cheap, and which tends to improve the status of the mental hospital, factually as well as in the eyes of the public. This system has been introduced in Bodo (on the Arctic Circle), where the mental hospital is conveniently located near the general hospital, and where special circumstances make it possible to reserve a well-equipped ward for a "nerve clinic".

In most places, however, special psychiatric hospitals are needed in addition to the mental hospitals, mainly for two purposes—for *observation* of certain psychotic states, in particular highly acute and presumably recoverable cases—and *treatment* of non-psychotic conditions, mainly neurotic. The ideal solution would be a full-sized psychiatric department at the principal general hospital of the district, equipped to handle all sorts of psychiatric cases and to give all types of treatment. This is hardly possible with less than 70 to 80 beds, but

on the other hand the number of patients should not exceed 140 even if the department is divided between two chief physicians. Only the municipal hospital of Oslo at Ullevål has such a department (140 beds). The psychiatric department of the Oslo University Hospital is administratively independent. It is located not on the hospital grounds but in a suburb, so as to give better opportunities for open air exercise and relief from city life. This advantage is possibly outweighed by the lack of close contact with the other departments, and it has proved necessary to attach a full-time psychiatrist to the general hospital for consultation work and for teaching of psychosomatic concepts.

Makeshift Arrangements Used

Apart from these ideal solutions, an interesting variety of makeshift arrangements have been established. At Lovisenberg (Oslo) there is a full-size department of psychiatry located in an ordinary hospital building, which puts certain limitations upon the activities. Certain hospitals have started on a modest scale with, for instance, 30 beds, some of them even scattered around on the medical wards, and with one or two full-time psychiatrists who are also doing consultation and out-patient work. These pioneer setups are doing an important job in making the general hospitals psychiatry-minded, and they therefore tend to grow very fast. In Bergen the professor of psychiatry is in charge of the local mental hospital, while his associate is working full time as a consultant in the general hospital, which has no psychiatric department.

So-called police wards are found in a couple of the largest cities. They specialize in highly acute cases which the police have to take care of (or help the family take care of), and the police psychiatrist is chief medical officer. They are regarded as somewhat of an anomaly, and owe their existence to the over-crowding of the mental hospitals, which frequently makes immediate admission impossible.

Independent hospitals for long-time treatment of neurotics and certain types of psychotics are being established in several places, with nothing but an indirect contact with any general hospital or mental hospital. These are run by semi-private health organizations.

All these psychiatric hospitals are, in principle, open, but most of them may have to keep a psychotic patient against his will, at least for a short period of time. Such retention has no actual foundation in law, but is based upon general rules of emergency. The forthcoming revision of the Mental Diseases Act will bring all such cases under the same rules and the same control system as in mental hospitals.

Mental hospitals are supposed to have an organized extra-mural activity, mainly as after-care for discharged patients, but also as "fore-care" for patients not yet admitted. Owing to lack of personnel this service is in most places rather unsatisfactory. Most of the other psychiatric hospitals have a regular out-patient department, mainly in order to increase their limited capacity. It is felt, however, that this out-patient service should not compete with the private practice of specialists in psychiatry, and where such specialists exist, the out-patient departments of the hospitals should limit their activity to diagnostic work.

HOSPITAL PROBLEMS ABROAD SIMILAR TO OUR OWN

By ROBERT H. KLEIN, Consultant,
Mental Hospital Service

The Eighth Annual Meeting of the World Federation for Mental Health was held in Istanbul, Turkey, August 21 to August 27. Some 240 individuals attended from 33 different countries, the largest group being European, and the next largest from countries in the Middle and Far East. The largest national delegations were from the United States and Turkey.

The theme of the meeting was "Family Mental Health and the State." Although this subject may not be of direct interest to those intimately concerned in the operation of large mental hospitals, many of the delegates at the meeting were very actively engaged in mental hospital problems in their own countries. A considerable number of hospital superintendents and officials of government mental hospital agencies were delegates.

To an American familiar with the problems in federal and state mental hospitals in the United States, it was interesting to discover that many of the same problems plaguing administrators here are also facing the administrators of mental hospitals in other parts of the world. The complaints most frequently heard were overcrowding and understaffing. In most countries, it was learned, too many mental hospital buildings are ancient and should be replaced because of obsolescence both because they have "worn out" and also because their design does not meet the needs of current psychiatric practices.

Government Hospitals Predominate

There was much interest in training programs for the various disciplines needed to staff mental hospitals. It is obvious that many of these programs are in an embryonic state; some are suffering from the lack of qualied teachers, while in a handful of countries programs appear to be as good as may be found anywhere.

The vast majority of mental hospital patients throughout the world are in institutions operated by the government of the country, of a province, of a city or the like. Privately owned institutions provide care for an extremely small proportion of the hospitalized mentally ill.

One important and significant difference between the mental hospitals in most of the countries as compared to the United States was the much lower percentage of older patients. Where the cultures of the countries tended to be highly "westernized" the number of seniles tended to be larger; but especially in the Middle and Far East the number of hospitalized seniles was extremely small, since it is customary for these individuals to be cared for at home by their families. Part of the reason is obviously the smaller degree of urbanization in these countries. Nevertheless, although no precise statistical data were available, it was apparent that there is an almost universal increase in the proportion of old people in mental hospitals throughout the world.

Information Exchange Desired

It was evident in talking to representatives of various countries that there is a very strong desire for an interchange of information about how hospitals in other countries—and particularly in the United States—are meeting their operational problems. It was interesting to note that none of the international agencies interested in mental health problems has as yet been able to meet the demands for this information. Many of these demands have not been made well known. It is unfortunate that an adequate vehicle has not yet been provided for the international interchange of information concerning the operation of mental hospitals, not only from the medical, but also from the administrative point of view.

A visit was made to the government Mental and Nervous Diseases Hospital opened in 1926 at Bakirkoy, a suburb of Istanbul. It has a present census of about 3200 patients, although it was built to accommodate 1500. Its patients include all classifications of mental illness including criminal insanity, drug addiction and alcoholism—and also one ward for mental defectives. We were told that the staff included 28 doctors, of whom 17 were psychiatrists; it was difficult to determine, however, just how much time they spent at the hospital because many of them were also on the staff at the University and did additional work both in private practice and at one of the several clinics in Istanbul. The physical facilities and the apparent quality of mental care left much to be desired but all of this must really be judged against the background of Turkish culture and economic problems. If one keeps this in mind, it is probable that the hospital at Bakirkoy should be given a higher ranking than first appearances would suggest.

There are two other government mental hospitals in Turkey, one with 600 and the other with 240 beds.

Joint Commission on Mental Illness Elects Officers

At the first Annual Meeting of the Joint Commission on Mental Illness and Health in Washington, D. C., on October 8th, Dr. Kenneth E. Appel was elected as President.

This announcement was made by Dr. Leo H. Bartemeier, Chairman of the Commission's Board of Trustees. Dr. M. Brewster Smith, of the Social Science Research Council, New York City, was elected Vice-President and Mr. Charles Schlaifer, National Association for Mental Health, was elected Secretary-Treasurer.

The next task of the Commission is to make formal application to the Surgeon General of the U. S. Public Health Service to grant the money for a three-year nation-wide study of the human and economic aspects of mental illness. Such a grant to a non-governmental agency was authorized by Public Law 182—Mental Health Study Act—put in effect this summer.

Dr. Bartemeier noted that it was entirely fitting that Dr. Appel should be President of the new Commission. It was Dr. Appel who first urged the need for a study and report on methods and practices of dealing with the mentally ill which would lead to a fundamentally new approach to this great problem.

Dr. Bartemeier expressed the hope that the study will actually get underway before the end of the year.

M. H. S. News & Notes

A. P. A. Nursing Office Discontinued

As of October 31, the office of Nursing Consultant to the American Psychiatric Association was terminated by direction of the A. P. A. Council. The decision was based primarily upon financial considerations. The responsibility of accrediting nursing programs in mental hospitals will be assumed by the National Nursing Accrediting Service. Psychiatric nursing consultation will be available from the National League for Nursing.

The Office of Nursing Consultant was established in 1942 under a grant from the Rockefeller Foundation, which continued its support until 1951. The Association was fortunate in securing outstanding leaders in psychiatric nursing to fill the office: Mrs. Laura Fitzsimmons (1942-46); Mrs. Lela Anderson (1946-48); Miss Dorothy E. Clark (1948-50) and Miss Elsie Ogilvie (1951-55).

One of the Nursing Consultant's prime functions was to provide advice, guidance and encouragement to psychiatric institutions in setting up or improving their nursing services and nursing educational programs. Another was to evalute the nursing departments in psychiatric hospitals with regard to developing affiliate education programs; after they had complied with the standards set forth by the A. P. A. Committee on Psychiatric Nursing, they were visited by the Nursing Consultant in order to be accredited by the Committee.

The Mental Hospital Service owes a particular debt of gratitude to Miss Ogilvie. In 1951, when she transferred from New York to the Washington office of the Association, she became the friend and adviser to the staff of M. H. S. She has worked with them on the Clothing, Food and Volunteer Committees; she has checked nursing items for professional accuracy and has spent many hours in educating staff members to the needs and problems of the nursing staff in mental hospitals.

She will be greatly missed by M. H. S., not only on personal grounds, but because her professional guidance has been invaluable to the Service. She has agreed, however, to serve as a Contributing Editor.

M. H. S. Consultant Honored

Dr. Addison M. Duval, assistant superintendent of St. Elizabeths Hospital, Washington, D. C., and a member of the M. H. S. Board of Consultants, was honored by the District of Columbia Medical Society in October. Dr. Duval was singled out for one of the two Certificates for Meritorious Service awarded annually by the society. He is the first psychiatrist to receive this award.

The honor was given to this "distinguished doctor of medicine for his outstanding contributions to the health and welfare of the children of the District of Columbia. Under his guidance the first Kiwanis Clinic for emotionally disturbed children was established in Washington, in 1948. With conspicuous success he has since sought and obtained professional and public support for additional psychiatric services in the public schools. The community owes this civic-minded humanitarian a deep debt of gratitude."

THE PATIENT DAY BY DAY

Ward Council Program Includes Personnel

A form of patient-government is being used on the men's total therapy (intensive treatment) ward at Napa (Calif.) State Hospital. The program consists of open meetings of patients and personnel assigned to the ward. It is planned and directed by a ward council made up of a president, vice president, secretary and ward greeter (all elected by the patients from their own group) and the psychiatrist, charge nurse, and social worker. Other staff members are invited to sit in as needed.

Attendance at the meetings is mandatory for all patients on the ward. The president conducts the meeting, opening it by announcing the names of patients who are leaving the hospital. The ward greeter then introduces new patients admitted to the ward.

The patients are permitted to speak freely, querying or making suggestions about hospital or ward routine. The staff members reply, so that all misunderstandings are promptly ironed out.

The questions raised are those of general interest to the ward. One of the most-discussed topics is the ward recreation program. Any individual problems which might be broached are referred to the psychiatrist or social worker for later discussion either in group therapy sessions or individual interviews.

The program is intended not only to develop better understanding between patients and employees on the ward, but also to help psychotic patients establish a group identity within a setting that does not enforce intimacy

Patients who formerly were withdrawn have been helped to take a more active part in group activities. One patient, for example, attended several of the ward meetings without response. He was a young schizophrenic who had been in the hospital for a year and half, and was transferred on trial to the total therapy ward from a regressed ward; his behavior varied from catatonic withdrawal to agitation, but he was no longer a behavior problem. His apparent disinterest in the ward council meetings was broken through when someone suggested boxing matches for the ward recreation program. Having once been an amateur boxer, he began to take part in the matches. He then became interested in the softball team and made good suggestions for improving it. His general condition began to show marked improvement and at the end of two months he was released from the hospital on indefinite leave of absence.

Patient Duo Entertains Closed Ward Units

A plan for making life a little brighter for patients on closed wards has been started at Patton (Calif.) State Hospital, with the help of two talented men patients. The men, both of whom have had extensive experience in the entertainment field, take the hospital's portable electric organ and an electric guitar around the various wards and play request selections.

Sketch Class Enjoys Off-Grounds Excursions

Part of the art clinic program at the VA Hospital, Palo Alto, Calif., is an outdoor sketch group. Any patient assigned to the art clinic may, with the permission of his ward doctor, join the sketch group. Weekly bus trips are made to nearby locations for sketching and to visit art galleries. The group also holds an off-grounds dinner party each Christmas and an annual all-day sketching trip and barbecue.

The trips are conducted informally. The only firm rule is that each patient shall stay within sight and hearing of the group unless accompanied by the therapist or a volunteer.

Through the common interest in art, the group is well integrated, despite the fact that it includes patients of both sexes, old and young, psychotic and nonpsychotic, with extreme variance in degrees of awareness, performance, talent, and varying social and educational backgrounds.

Women's Library Club

By a Patient, Connecticut State Hospital, Middletown, Conn.

Activities here are directed with the definite goal of preparing patients toward normal routine. Thus, when they resume life in the outside world, it will be less difficult to fall into regulation procedure. The social side of the picture is stressed as very important.

To this end, the Connecticut State Hospital bends every effort. There are many clubs and organizations for men and women, also many pleasurable privileges with the social end in view.

I cite, for example, our Literary Club. This was founded about ten years ago, and is a highlight in hospital life.

Limited to women, the Club is open to patient membership. It was organized by a church group of women volunteers who wanted to do something for the hospital and have sponsored this organization enthusiastically since its inception.

Referring to the activities, in which the patients participate, it is suggested that each patient-member bring an item of current interest to be read after a brief greeting by the president and the secretary's review of the minutes of the previous meeting.

The highlight of the meeting is the guest speaker. The subjects covered are recent books, travel, nature studies, music and many other topics which are of interest.

As part of the ladies' contribution, a check-list of the birthdays of all members is kept and a small gift is presented to each member whose anniversary occurs in the month the meeting is held.

Gay social chat, informal discussion, and the serving of refreshments brought by the volunteer ladies bring to a close the delightful occasion, to which the patients look forward eagerly. Our Literary Club furnishes an important link between hospital routine and the outside world. Its effect and value to patient morale are definitely far-reaching. The response is surprisingly favorable, emphasizing the fact that patients are "real people" with all that thought implies.

DEPARTMENTS

State School Sponsors Three-Day Parents' Visit

A three-day orientation program for parents of retarded children was held by the Enid (Okla.) State School, as the result of Superintendent Anna T. Scruggs' belief that actual experience was the best answer to their questions about the school. Mrs. Scruggs invited the Tulsa Council for Retarded Children to send groups to the school for three days. To date three groups have visited.

The parents arrived equipped with white uniforms. They were housed in the employee residence and called at 5:30 a.m. for breakfast with morning shift personnel. They were given actual work experience in typical cottage situations, in schoolroom classes, in arts and crafts groups and in attendant training classes.

Critique periods with staff members represented the only "front office supervision" of the visitors. The parents' comments were highly favorable towards both the orientation plan and the school's program. Mrs. Scruggs feels that the plan is mutually beneficial to the school and the parents.

Ohio Discontinues Supplying Maintenance

The Ohio Department of Mental Hygiene and Correction has stopped furnishing maintenance for employees. Over 5300 employees of the Department had been receiving some form of maintenance, for which payroll deductions were made. The services ranged from complete housing, commissary privileges, household help and laundry, to one prepared meal a day or personal laundry only.

An exception to the new ruling is that living quarters will be provided, where available, on an equitable rental scale. No state-paid household help will be provided, however, and food may not be requisitioned from the institution's storerooms or kitchens. Laundry service is now restricted to house linens of furnished living quarters and to uniforms required for special services. Prepared meals, the maintenance item affecting 3300 of the 5300, are provided on a cash basis in institution cafeterias.

In announcing the new plan, which became effective October 1, Dr. John D. Porterfield, Director of the Department, noted that the difficulty of the old maintenance system lay in "keeping deductions equivalent to services furnished and in avoiding any possibility that resources intended for patients and inmates be diverted even in small part to unwarranted employee benefit." The only salary adjustment made necessary by the new plan is the scale for physician specialists. Most other employees have benefited from recent amendments to Ohio's Civil Service Classification - Compensation Act. Those who have not, and for whom the no-maintenance plan will work hardship, will be given individual consideration.

General Hospitals Offer Clinic Facilities For Follow-Up of State Hospital Patients

By EDWARD E. MUELLER, R.S.W.

Director, Psychiatric Social Work
New Jersey State Hospital, Greystone Park

How to provide follow-up services for some 1200 patients on convalescent leave with a mere handful of psychiatric social workers was the problem faced at Greystone Park two years ago. Even if the hospital had been able to recruit the extra caseworkers its budget provided for, the problem would only have been lessened somewhat. Traveling, as was necessary, the northern part of the state to make home calls, each social worker usually averaged but one or two interviews a day.

A plan was worked out in cooperation with a number of private general hospitals strategically located throughout the area served. Eight of them agreed to let our hospital operate "convalescent clinics" on their premises, making the space available free to us as a community service. Similar arrangements were made with two American Red Cross chapter offices and two Y.W.C.A.'s in cities where the local hospitals could not provide sufficient space.

In short order, thirteen convalescent clinics were set up, including the one at Greystone Park itself. A form letter was sent out over the signature of the hospital's superintendent, Dr. Archie Crandell, notifying the responsible relative of each patient on convalescent leave that the home visits would henceforth be replaced by the clinic system. This system would, it was explained, make it possible for the social workers to see the patients more often, and at regular intervals. As soon as the clinic schedules were worked out, the relatives were given definite appointments for bringing the patients to the clinic nearest them.

Pre-Release Instruction Given

For patients leaving the hospital on convalescent leave (which lasts about a year and can, if necessary, be extended up to another year), the Director of Social Work conducts a group meeting. Each patient is given a card with the name of the social worker assigned. He is instructed to write to the social worker within ten days after leaving the hospital and every thirty days thereafter, stating how he is getting along and discussing any problems that arise. He is informed about the convalescent clinics, and told that he will receive a notice telling him when to report.

If for some reason the appointments cannot be kept, the patient is urged to notify the clinic immediately so that the time may be assigned to another patient and a more convenient time arranged for him.

It is emphasized that if problems arise between the monthly letters or between clinic visits, the patient should get in touch with his social worker immediately. In this way the difficulty can be dealt with before it reaches such proportions that the patient has to return to the hospital.

Relatives' Help Asked

At the same time as the group meeting for departing patients is held, a similar but separate one is conducted for their relatives. The relatives are also instructed to keep the social worker informed of their patient's adjustment, to report any existing problems and to encourage attendance at the convalescent clinics.

The clinic sessions are conducted three days a week. The social workers spend the other two days at the hospital, catching up on recording, correspondence, and similar tasks.

The appointments are scheduled on a rotating system. If a patient seeks an interim appointment, the social worker will of course arrange it. The routine scheduling is handled by a clerical worker under supervision of the Director of Social Work.

Ten interviews a day with patients are scheduled for each clinic. A listing of appointments is given each caseworker a week in advance, so that the worker can study the record of each patient scheduled. The listing is returned to the hospital, showing the number of appointments kept, cancelled or broken, and any additional interviews that took place. The average number of interviews per day at each clinic is 14—seven patients and a relative apiece, individual interviews being given to each.

After over a year's operation of the convalescent clinics, we can see many advantages not only for the patient and his family, but also for the social service staff and the hospital. First and foremost, of course, is the benefit of continuous casework services to a patient coping with the problems of readjustment. This is in contrast to the infrequent home visits which many viewed as a routine check-up "for appearance's sake." Then too, the patients prefer going to the clinic; as one patient put it, "If a social worker comes to the house, some snoopy neighbor wonders who's coming to call in a State car. When you go to a hospital, nobody knows what you're going for."

Working in the clinic setting has brought forth new skills and techniques among the Social Service staff. One of the caseworkers explained it thus, "Knowing that the patient or relative has had to travel some distance to you, perhaps in snow or rain, gives you a certain sense of humility and a desire to sharpen your skills and techniques to the extent that you will give him something to take away with him, so that he will wish to return to see you.

Cooperative Casework

The closer degree of cooperation with the various hospitals and social agencies in the communities where the clinics are located has brought tremendous dividends. There is an awareness of the State hospital's efforts to supervise the patients it releases and to help them re-establish themselves. Cooperative casework has increased by leaps and bounds with many community agencies. "We're willing to report to you how John Smith is getting along," they say to the caseworker; "We see the family and we will let you know any developments." Cooperative arrangements like these have cut down duplication of effort, to the benefit of all concerned.

The convalescent clinics have proven to be our answer to giving adequate follow-up casework services to a large number of patients despite a small casework staff.

The Economy of Increased Appropriations

By ALFRED PAUL BAY, M.D., Superintendent
and PAUL E. FELDMAN, M.D., Director of Research & Education
Topeka, (Kansas) State Hospital

A LEGISLATOR contemplating the appropriation of millions of dollars for mental hospital operation, especially during an era of high taxes, may well be reluctant to grant a request for an increased budget merely because it will permit "better" or "more humane" or "more progressive" care. He feels that he is entitled to be told what the money will buy. He can understand and visualize a mile of highway or a new school. He can visualize a new hospital building. But it is not easy for him to accept the fact he should allocate considerably more money just so that a steadily rising patient population may be more comfortable. And we are a little unreasonable to expect him to.

The Cleveland Mental Health Association, fully cognizant of the need for convincing data about the return on investment in psychiatric care and treatment, appointed a "Businessmen's Committee on Mental Health." This committee dealt with the specific question, "Can increased expenditures for additional mental hospital personnel eventually result in a savings to the tax payer?" Their conclusions, published in June 1954, indicated that studies to date do not provide an answer to this question.

Evaluating Human Values

Those of us who do attempt to answer it find that our path is strewn with obstacles because we are unable to evaluate in dollars the human factors which enter into our computations. How can one place a numerical rating on a sound, humane, therapeutic program in contrast to a stagnant, purely custodial one? Who can assay in dollars and cents the loss to a family, to the community, or to the Government, when a wage-earner is incarcerated? Where in our volumes of statistics do we appreciate the earlier return to society, the family, friends and others, of an individual who is rehabilitated in six months instead of six years? Where is the earlier return to society reflected in our national income statistics? Where do we reveal the savings to the taxpayer which occur when by an improved therapy program we discharge 82% of all first admissions within one year, instead of the 62% which were discharged in a comparable period in the past?

Two Measurable Factors

Previous studies, similar to that of the Cleveland group, have shed little light on the subject primarily because of the inability to convert many of the obvious accomplishments of mental health programs into cash values so that they will be acceptable to a statistician, a biometrician, or to a legislator. Studies which have attempted to discover an economic justification for increased expenditures in mental hospital operation fall into two categories: the first kind begins with an apology for the paucity of data and ends with a plan for collection of more valid statistics which will supply some of the sought-for answers twenty years hence; the second kind has the presumption to suppose that the trivial and heterogeneous bits of information it supplies are significant and warrant broad generalizations. They are alike in that they invite the criticisms of being shallow, inconclusive and irrelevant, which in turn discourages anyone else from venturing into this chartless field of inquiry.

The authors of this paper do not hope to prove anything; but do hope to indicate that relevant and suggestive evidence is available. The cost of the care of patients is readily measurable in dollars and cents. The recent report from the Model Reporting Area indicates that mental hospital population is growing at the rate of 15.2% every six years. Here are two areas which might be studied intensively. Will sound investment of additional money prevent the increase in average, daily, patient census or better yet—reverse this trend? If a hospital census is kept stationary, or decreased, this precludes the construction of additional hospital beds at approximately $5,000-$20,000 each. Are these not savings to the taxpayer?

Justifying Extra Expenditures

The Topeka State Hospital is currently (1954) operating at a per-capita of $5.34 which is above the minimum set forth in the "Standards for Psychiatric Hospitals and Clinics" suggested by the American Pyschiatric Association. We are repeatedly asked to justify this expenditure since the average mental hospital is operating at $2.70 per capita (1953 figure, latest available).

To do so, we collected statistics from representative 1,000-2,000 bed mental hospitals throughout the country. Inquiries were sent to 54 mental hospitals and responses came

from 22.* Most of the hospitals which responded serve rural areas rather than large population centers. Training schools and schools for the mentally deficient were excluded from the study. The questionnaire was limited to three areas: per-capita costs—salries, wages and other operating expenses (exclusive of capital investments); admission and population statistics; professional personnel statistics.

Seventeen of the reporting hospitals seem to fall into a pattern characterized by:

1) Low per capita cost in no way approaching the minimal $5.00 per day per patient specified in the APA "Standards for Psychiatric Hospitals and Clinics." The costs varied from $1.47 to $3.68 per patient per day in 1954. The average per capita cost in 1954 was $2.64.

2) Salaries and wages varied from $339 per patient per year to $1455 per patient per year, with the average for the group of $631 per patient per year in 1954.

3) Other operating expenses varied from $190 per patient per year to $554 per patient per year, with the group average at $365 per patient in 1954.

4) A progressively increasing daily resident patient census for all 22 hospitals responding to the questionnaire; the average population rose from 1,708 in 1945 to 1,858 in 1954, or an increase of 8.7%.

5) Progressively increasing total annual admissions; in 1954 the total admissions averaged 670. Re-admissions maintained the same relative proportion to new admissions from 1945 to 1954.

6) Deficiencies of professional personnel in all categories:

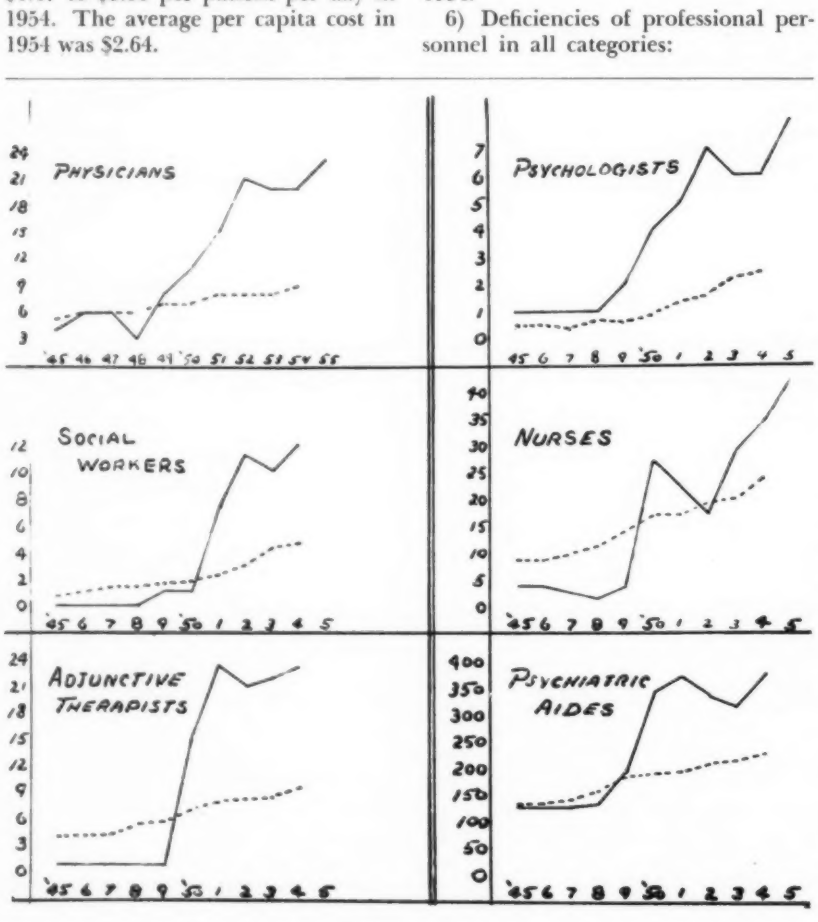


Figure 1

Graphs showing the average number of professional personnel per hospital for the successive years from 1945 to 1954.

solid line = Topeka State Hospital.

broken line = Average of 22 reporting hospitals.

Physicians: Greatly understaffed. The 22 hospitals averaged only 9 physicians for an average of 1,858 patients. The answers did not reveal the competence of these physicians but did show that very few of them have the equivalent of Board Certification.

Nurses: The most critically understaffed of all professional categories. In 1954 the hospitals had an average of 24 nurses; one hospital had only two nurses.

Psychiatric Aides: The answers did not reveal the amount of basic training, but there was an average of only 226 aides per hospital, or one aide for each 8.2 patients.

Adjunctive Therapists: Another deficient category with an average of 10 adjunctive therapists per hospital in 1955.

Social Workers: Similarly deficient. The group averaged 4.4 for each hospital in 1954.

Psychologists: An average of 2.3 per hospital for 1954, or approximately one psychologist for each 800 patients.

"Average" Hospital Deficient

In general then, the picture of the "average" hospital in this group is none too bright. Figures over the past ten years show that most of them ten years ago (1945) were operating at an average of $1.04 per patient day, and that they have laboriously climbed to an average of $2.64 per patient day in 1954. This increase in per capita expenditure is partly offset by the fact that over the same interval the purchasing power of the dollar declined from $1.30 to $0.87 (source: U. S. Consumer Price Index).

Increases in members of professional staff have been equally slow and the average hospital is deficient in personnel in all disciplines. For example, it has taken the "average" of the reporting hospitals three years to increase their medical staff by one physician! Over the ten year period

** Hospitals responding: Alton, Ill.; Moose Lake, Minn.; Central S.H., Ind.; Cherokee, Iowa; Augusta, Maine; Western S.H., Ky.; Arizona S.H.; Fergus Falls, Minn.; Farmington, Mo.; Fort Supply, Okla.; Eastern S.H., Va.; Allentown, Pa.; Montana S.H.; Crownsville, Md.; S.W. State Hospital, Va.; Metropolitan S.H., Cal.; Winnebago, Wis.; Jamestown, N. D.; Athens, Ohio; Yankton, S. D.; Wernersville, Pa.; St. Lawrence, N. Y.*

(1945-1954) the average medical staff increased from six to only nine. During this period, the "typical" mental hospital population has shown a progressively ascending growth curve, with no apparent end to this growth.

Extra Staff Means Lower Population

In contrast to this average mental hospital, the Topeka State Hospital, operating at a per-capita-cost above the minimum stipulated by the A.P.A. and meeting minimal standards in all professional categories other than registered nurses, has shown a progressively *diminishing* growth curve with approximately a 25% reduction in average daily patient census during the past ten years. In comparison, the group of hospitals included in this study showed an average 8.7% *increase* in daily patient census.

Space does not permit publication of all the available figures. However, the table on this page shows a comparison of the Topeka State Hospital with four of the reporting hospitals for the years 1947 as contrasted to 1954. Almost any of the other reporting hospitals would have served as well. In 1947, all five hospitals are strikingly similar in costs of operation and in composition of patient population, as well as in staffing pattern.

It seems significant from this table that in 1954 the substantial differences in professional manpower at the Topeka State Hospital and the other hospitals, has contributed at least in part to the difference in their respective in-patient populations. This thought becomes more provoking when it is realized that unless certain alterations in staffing are made, the other hospitals face the fact that they will continue to grow and grow in patient census.

Other Comparisons

It should be pointed out that the other hospitals have had substantially higher admission rates than Topeka in the past, but the recent figures show that Topeka's total annual admissions, which exceed admission figures for any previous year, are now comparable to those of other hospitals. Despite this, the number of residual patients at Topeka continues to decrease.

Four of the reporting hospitals did not fit into the pattern of the other eighteen. Two of them showed declining patient-populations in spite of operation at a substantially lower per capita cost than Topeka. Two others show increasing patient-populations in the face of very respectable per-capita expenditures. Our personal conversations with those familiar with the programs of these four "exceptional" hospitals have revealed reasons for the discrepancies not related to cost of care. Administrative decisions to close or open the doors to admissions, to limit or expand the criteria for release; the intra-state transfer of large groups of patients between hospitals; and the handling of special groups such as the criminally insane; these and similar factors explain the paradoxical findings of the few exceptions to the rule.

Comments

Prior to 1950 there was no selectivity of patients at the Topeka State Hospital, and all admissions had to be approved by the Superintendent or the Clinical Director. An Admissions Committee was created in 1950 and the admission process has since been selective, but its influence on census is questionable (1950 was the period of lowest admissions; and since that time admissions have been climbing steadily).

In general, patients are not admitted for whom other community resources can be found. This eliminates admission of some "short term" patients such as alcoholics, psychoneurotics and "quiet" seniles. However, those patients gaining admission are probably more gravely ill than those admitted to other state hospitals in the study.

No classification of patient is categorically excluded from Topeka State Hospital. An analysis of admissions

	Year	T.S.H.	Hospital "A"	Hospital "B"	Hospital "C"	Hospital "D"
Average daily census	1947	1,844	1,777	1,748	1,958	1,831
	1954	1,422	2,062	2,165	2,107	1,942
Per capita cost	1947	1.15	1.87	1.20	1.23	1.25
	1954	5.34	3.04	2.25	2.27	2.54
Salaries & wages	1947	316,682	654,142	266,566	519,487	375,091
	1954	1,954,036	1,389,544	1,050,027	1,057,994	933,085
Other expenses	1947	461,146	569,359	497,340	432,787	460,607
	1954	756,683	901,472	725,597	689,770	867,813
Physicians	1947	6	8 *	5	10	4
	1954	20 **	11	12	6	6
Social workers	1947	0	5 *	1	3	1
	1954	12	6	6	2	3
Psychologists	1947	1	3 *	1	3	1
	1954	6	2	3	2	3
Aides	1947	128	166 *	124	131	163
	1954	362	183	187	200	233
Adjunctive therapists	1947	1	14 *	3	6	9
	1954	23	20	15	3	14

* 1950 figures, 1947 figures not available.

** Plus 23 resident physicians.

by diagnoses would therefore probably be very similar for this and other public mental hospitals.

A substantial work load is added to the professional staff at the Topeka State Hospital by the selection process, since (except in emergencies) pre-admission workups include complete social and medical histories, patient interviews, family and community agency interviews, and so on.

The drop in patient census at Topeka State Hospital from 1948 to 1952 is in part explained by the reduced admissions over the same period—but not completely, because the census has declined for 3 or more years in spite of a new record admission rate.

A further study is now in progress which will analyze cost per hospital stay of all admissions to Topeka State Hospital over the past ten years.

Attention is called to the fact that the graphs in Table 1 show the increase in actual numbers of employees. The ratio of these employees to the patients served would make a more startling contrast. For instance, in view of the reduced patient population the increase of physicians at Topeka State Hospital from three in 1945 to twenty-three in 1955 has made the number of patients per physician drop from 616 to 58.

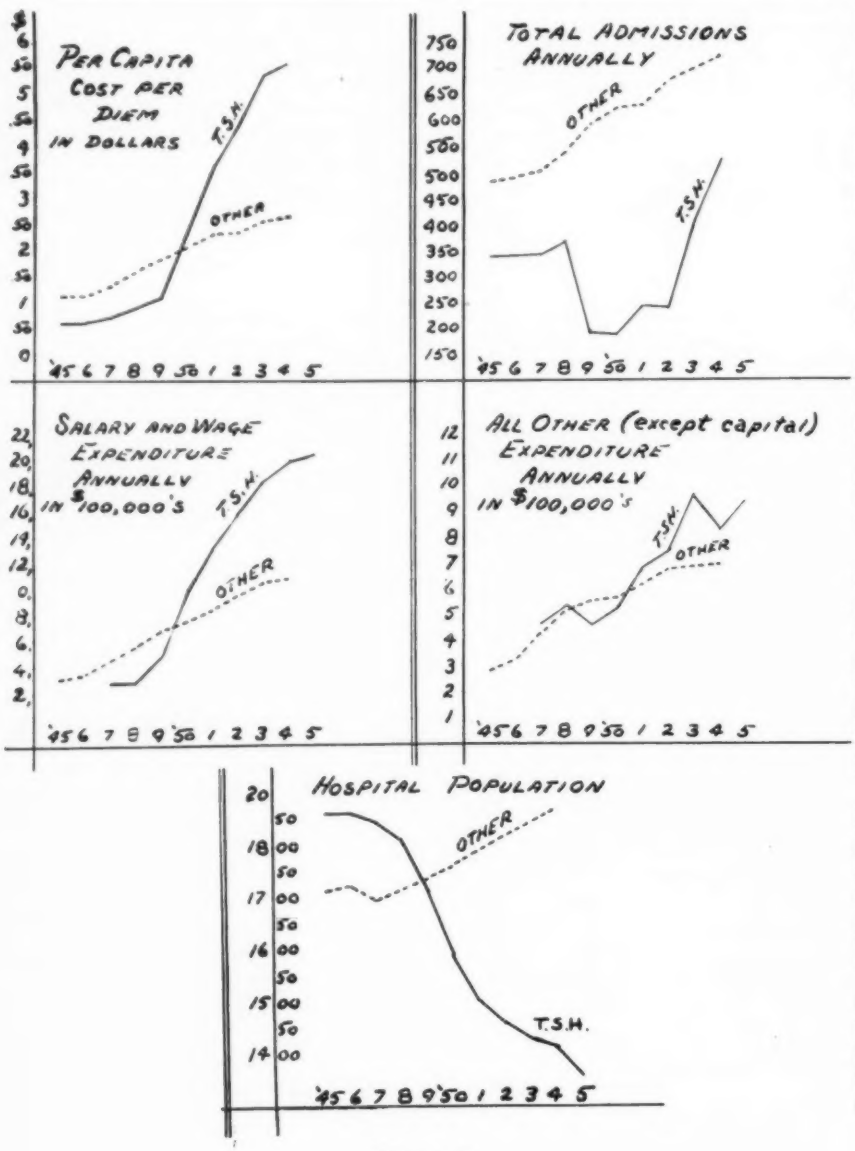


Figure 2

Graphs showing admissions, costs and populations of the 22 reporting hospitals as contrasted to the Topeka State Hospital.

Summary and Conclusion

Eighteen out of twenty-two mental hospitals responding to a questionnaire indicated that their average daily patient census during the past ten years was remaining relatively stationary or was progressively increasing.

Two hospitals showed an increasing patient census in spite of per-capita costs which ranged well above the average.

Patient/employee ratios are only very slightly more favorable for patient treatment than they were ten years ago.

We believe that many other significant comparisons might be made with data now available from mental hospitals throughout the country and we would encourage the collection and publication of similar and additional data, by agencies equipped for such a task.

The conversion of the Topeka State Hospital into a teaching and training center is undoubtedly an all important factor in our improved therapy program and growth curve. But even this would not have been attainable had not adequate appropriations been budgeted to provide for the additional personnel.

If the Topeka State Hospital were faced with an in-patient population growth similar to that shown by twenty comparable hospitals, it would require a capital plant *expansion* expenditure of 10 million dollars by 1955 or 17 million dollars by 1966. This does not include the increased cost of daily care of an increased patient-population. We feel that Topeka State Hospital has saved at least this amount of money by its increased expenditures for staff and program.

(Requests for statistical compilations upon which this paper is based should be addressed directly to the reporting hospitals concerned in this report.)

Saskatchewan Training School, Moose Jaw, Sask.

Architect and Engineer: H. K. Black, B.Arch., F.R.A.I.C., M.E.I.C.

This is the first major psychiatric hospital construction in the Province since 1921. Until 1945 mental defectives were cared for in the two provincial mental hospitals, but temporary buildings were provided at the end of World War II. In 1949, the Province authorized this entirely new institution, with an ultimate capacity of 1,500 patients. Of these 750 will be very low grade, 350 middle grade and the remainder high grade patients with social and behavior problems.

Detail planning began in 1949. The original committee consisted of Dr. F. B. Mott, Deputy Minister, Dr. D. G. McKerracher, Director of Psychiatric Services, Dr. R. O. Davison, Superintendent of the Saskatchewan Training School at Weyburn, together with the architect, H. K. Black. Mr. Alston G. Guttersen, then architect with the U. S. Public Health Service, contributed valuable guidance in the early stages of the planning development.

KEY TO NUMBERS
1-8 FEMALE LOW GRADE UNITS
9-17 MALE LOW GRADE UNITS (FUTURE)
18 INCINERATOR (FUTURE)
19 VISITORS BUILDING (FUTURE)
20 TUNNEL CONNECTING FEMALE LOW GRADE UNITS AND HOSPITAL—ABOVE GRADE
21 LOW GRADE KITCHEN BUILDING (FUTURE)
22 HOSPITAL AND ADMINISTRATION BUILDING
23 TUNNEL CONNECTING HOSPITAL AND LAUNDRY BUILDING — BELOW GRADE
24 TUNNEL CONNECTING HOSPITAL AND LAUNDRY BUILDING — ABOVE GRADE
25 GREENHOUSE (FUTURE)
ROOT CELLAR UNDER
26 LAUNDRY BUILDING
27 MAINTENANCE, STORES AND BOILER HOUSE
28 PUMPHOUSE AND RESERVOIR
29-34 STAFF RESIDENCES
35 CHAPEL (FUTURE)
36-38 FEMALE COTTAGES (FUTURE)
39-43 FEMALE COTTAGES
44 TUNNEL CONNECTING FEMALE COTTAGES AND KITCHEN DINING BUILDING—BELOW GRADE
45 TUNNEL CONNECTING HOSPITAL AND KITCHEN DINING BUILDING — ABOVE GRADE
46 KITCHEN DINING BUILDING
47 TUNNEL CONNECTING KITCHEN DINING BDG. AND SCHOOL AND REC. BDG.—BELOW GRADE
48 SCHOOL AND RECREATION BUILDING
49 TUNNEL CONNECTING KITCHEN DINING BDG. AND MALE COTTAGES—BELOW GRADE
50 TUNNEL CONNECTING SCHOOL AND RECREATION BDG. AND MALE COTTAGES — BELOW GRADE
51-55 MALE COTTAGES
56-58 MALE COTTAGES (FUTURE)
59 GARAGE
NORTH
MOOSE JAW CREEK
MOOSE JAW CREEK
SITE PLAN OF SASKATCHEWAN TRAINING SCHOOL, MOOSE JAW
H. E. BLACK
ARCHITECT AND ENGINEER

Description of Total Establishment

By H. K. Black, B. Arch. F.R.A.I.C., M.E.I.C.
Architect and Engineer

THE SITE of this establishment, about 2½ miles south of the city of Moose Jaw, besides being near the larger population centers of the Province, is in good farming land, and with water supply and sewage systems available from the city. The land is flat, above possible flooding level, and the nearby Moose Jaw Creek can provide irrigation for market gardening work.

The actual construction has continued since the fall of 1950, with funds being voted year by year by the Province. A Dominion Government grant of $1,500 per bed was also made available for this and similar provincial institutions meeting certain minimum standards.

The original plan was for the establishment to be occupied by stages. The first phase was to contain 600 patients, the second stage would increase it to 1,100 and the third and final stage would bring it to 1,500. Owing to urgent admission needs the first stage construction continued to 1,100, the present capacity. During the coming year a further appropriation is expected, bringing the ultimate capacity to the planned 1,500.

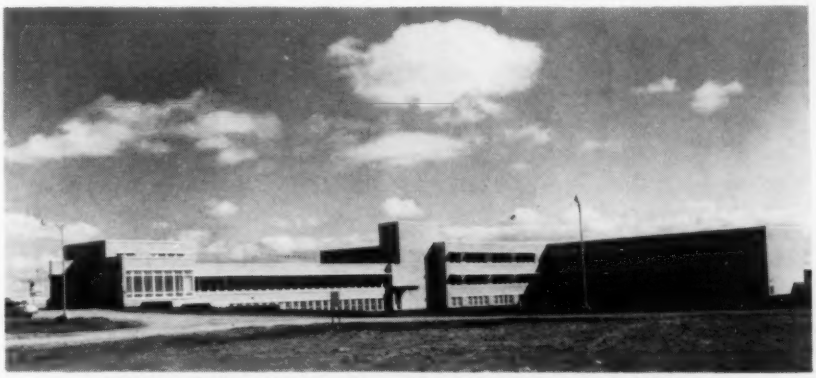
It was decided that a scheme based on multiple single story buildings connected by underground tunnels or passageways would best meet all requirements. Full consideration has been given to the extremes of climatic conditions prevailing in Saskatchewan and underground tunnels or passageways are provided for use during the severe winter weather and heavy storms. Louvred sun shades are provided generally on rooms having southern exposures. Paved roads, for movement of patients, will be provided throughout the establishment. Walls and roof of all buildings are well insulated against extreme low winter temperatures and high summer temperatures. All window and door openings are weatherstripped. All sash are double glazed.

Segregation of male and female patients is achieved through planning and distances rather than by barriers. The more retarded are separated from the others in different areas of the site. This permits grouping of the outdoor recreational facilities and community buildings adjacent to the higher grade patient areas.

The central building of the establishment is the two-story Administration and Hospital Building which provides offices for the Superintendent and key personnel, and locker facilities for the entire staff. Doctors' offices and examining rooms, laboratories, pharmacy, X-ray and all facilities for a complete hospital are provided, including an operating suite and central sterile supply room. The hospital has 200 beds, including the pediatric section and nursery, with a maximum of 25 patients per nursing unit. Private isolation rooms and an admission unit are provided. The building is reinforced concrete throughout, with exterior masonry walls and interior tile partitions. Wall finish is generally plaster with enamel paint. The floors are terrazzo and acoustic treatment is used extensively on the ceilings.

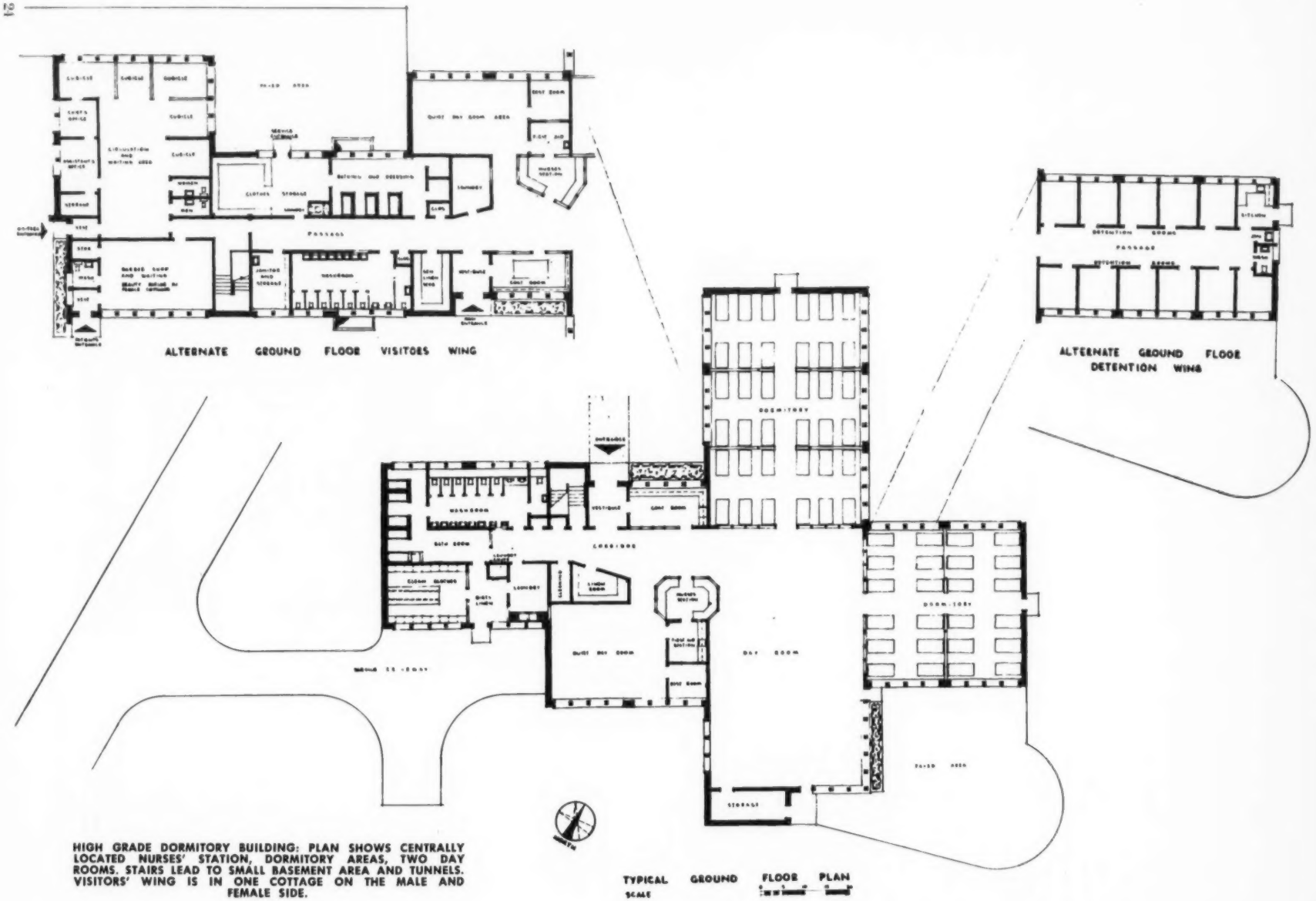
The higher grade patients are housed in 10 separate Dormitory Buildings west and south of the Administration and Hospital Building, each having a capacity of 60 patients; five buildings to the west of the group are for female and five to the south are for male patients. Running between the male and female dormitory buildings is the School and Recreation Building and the Kitchen-Dining Building, which are used by both male and female patients.

The Dormitory Buildings are all one story so that the patients can readily get outside for recreation and fresh air without the difficulty of



View of the Hospital and Administration Building

Exterior of typical High Grade Dormitory Building



HIGH GRADE DORMITORY BUILDING: PLAN SHOWS CENTRALLY LOCATED NURSES' STATION, DORMITORY AREAS, TWO DAY ROOMS. STAIRS LEAD TO SMALL BASEMENT AREA AND TUNNELS. VISITORS' WING IS IN ONE COTTAGE ON THE MALE AND FEMALE SIDE.

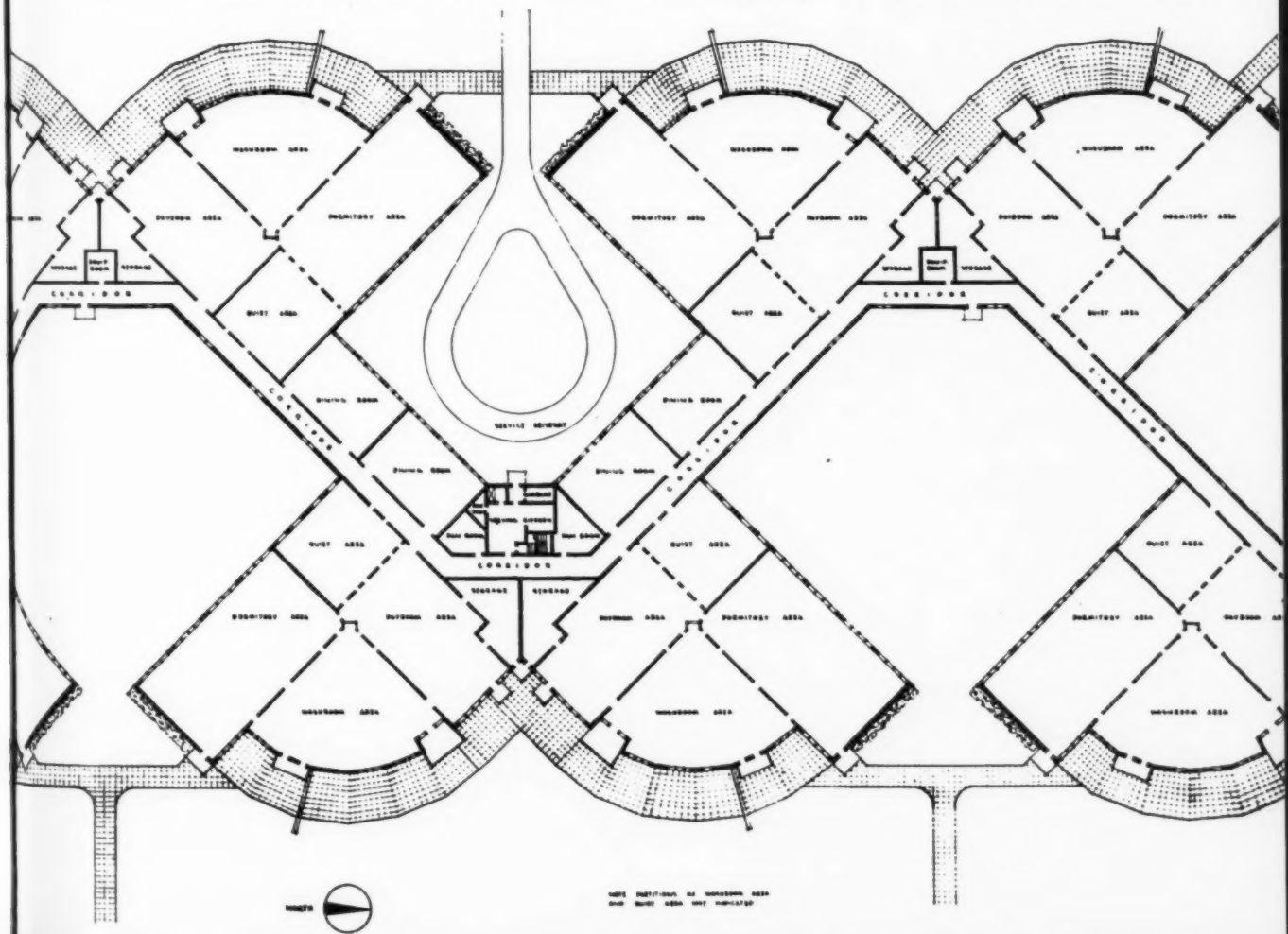
stairs. Each building contains two dormitories – one with 24 beds and the other with 36 beds and a centrally located nurses' station provides maximum observation. There is a large day room and a smaller quiet day room for patients' use. There are the usual washroom and coatroom facilities in each building, together with a small treatment room. Each unit has its own mechanical equipment room and locker room for storage of personal effects. One unit on each of the male and female sides is set up to include either a beauty or barber shop, office for the Chief Nurses, and a general waiting room with visiting alcoves for the convenience of relatives and friends of the patients.

These buildings are all inter-connected by underground tunnels and also connected to the Dining Building and School and Recreation Building. Patients will use the outside walks as much as possible, but because of heavy blizzards and extreme low temperatures, tunnel facilities are required.

The School and Recreation Building is now under construction and is scheduled for completion November 1, 1955. The school has a large auditorium-gymnasium for games, folk dancing, physical culture, movies and will be used for church services. In this building there are rooms for Manual Training, Home Economics and Occupational Therapy. Large classrooms, opening directly outside, and separate assembly rooms are also provided. There are bowling alleys for patient and staff recreation. A curling rink and outdoor skating rink will be provided, together with playing fields and picnic grounds.

The Kitchen-Dining Building at present provides central food service for the entire establishment. It is adjacent to the high-grade dormitory area. The kitchen is large and well lighted; the building also includes facilities for baking, preserving, vegetable preparation, meat preparation, and milk pasteurization. A large storage area is provided, including deep freeze rooms and adequate walk-in refrigerator cold storage rooms. A large root cellar and greenhouse is scheduled for construction as soon as possible. The dining area is divided by folding doors to provide adequate space for each cottage. This can be adjusted as the supervisory staff sees fit. There are two cafeterias – one for male and one for female patients. In addition, there are separate staff dining facilities and also a private dining room.

Facilities for housing the Low Grade patients are located to the north of the hospital building. There will be two sections, male and female, only one of which is now completed. Each section will consist of eight interconnected 48-bed nursing units. The emphasis is on central control and supervision, which has resulted in a rather radical and radial shape of building. Each nursing unit provides dormitory facilities, day room facilities, washrooms and so on, together with quiet rooms. These buildings are



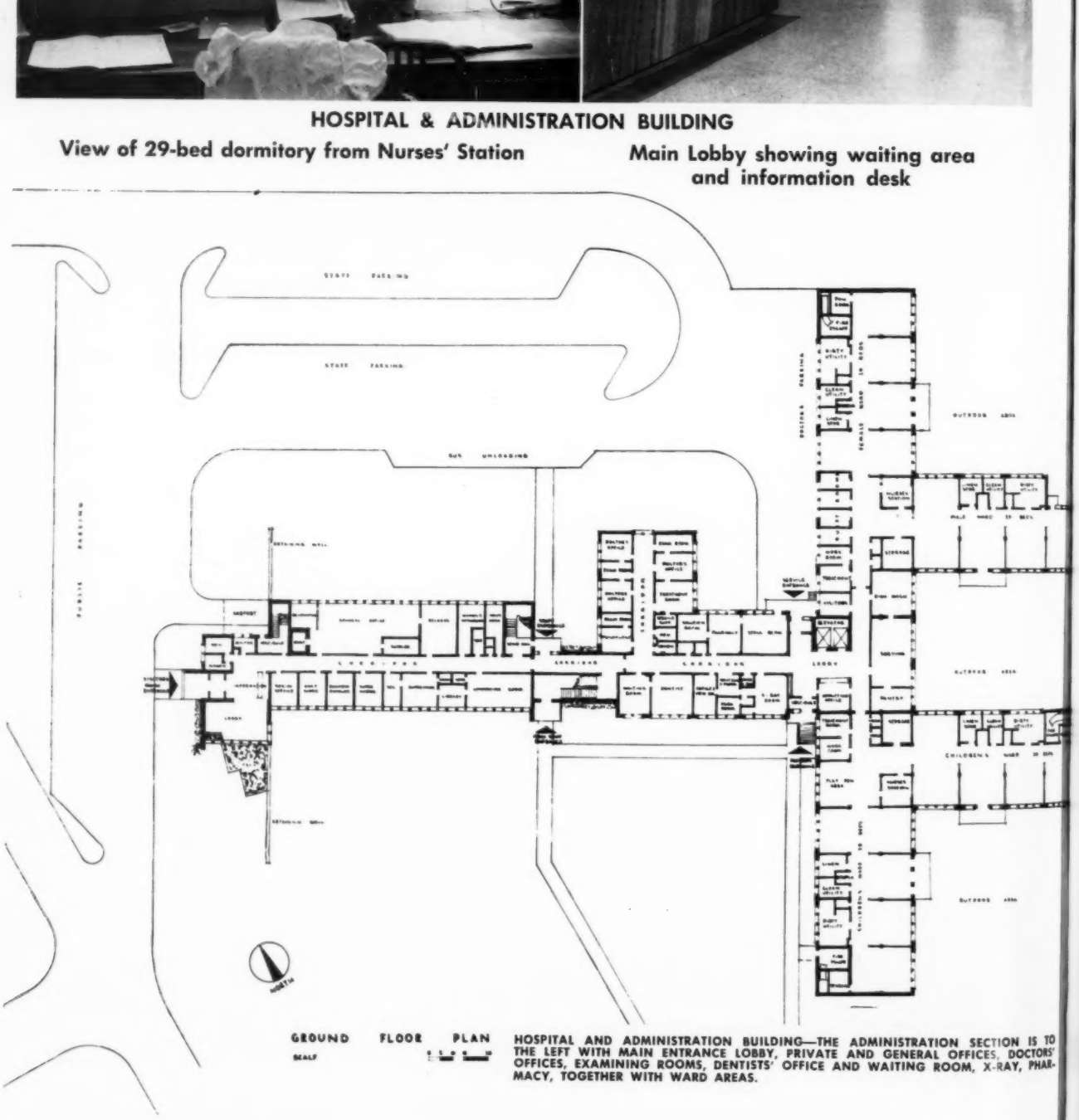
GROUND FLOOR PLAN

SECTION OF SYMMETRICAL BUILDING FOR LOW-GRADE PATIENTS

HOSPITAL & ADMINISTRATION BUILDING

View of 29-bed dormitory from Nurses' Station

Main Lobby showing waiting area and information desk



GROUND FLOOR PLAN

HOSPITAL AND ADMINISTRATION BUILDING—THE ADMINISTRATION SECTION IS TO THE LEFT WITH MAIN ENTRANCE LOBBY, PRIVATE AND GENERAL OFFICES, DOCTORS' OFFICES, EXAMINING ROOMS, DENTISTS' OFFICE AND WAITING ROOM, X-RAY, PHARMACY, TOGETHER WITH WARD AREAS.

constructed with acoustically treated ceilings, generally glazed structural tile dadoes with plaster above and terrazzo floors. Separate dining facilities are provided for patients in these buildings, one dining room to serve two nursing units. When the second section of these units is authorized, there will be separate visiting rooms and a separate kitchen.

Essential staff only are housed near the establishment and six residences are provided south-west of the Administration Building. These are for the Superintendent, Director, Chief Engineer, and senior medical men. All other members of the staff are to reside in the city of Moose Jaw. This was considered advisable so that the staff could take an interest in community affairs and not have the Training School as their sole interest.

Utility and Maintenance Buildings

East of the Hospital are the Utility Buildings, which include a large laundry and dry-cleaning plant. In addition to the equipment room, there are necessary storage facilities, finishing rooms, mattress sterilizing room and dry-cleaning plant. Immediately adjacent to the laundry building is the Boiler House and Maintenance Building. Three 15,000# per hour oil-fired steam boilers, operating at 250# pressure, supply heat and steam for the entire institution. Also in the Boiler House is the main electrical transformer bank and distribution centers. The Maintenance Building provides heavy storage space and central storage for the maintenance shops. Each trade has its own shop in this building. Canadian National Railway spur track facilities are brought to it and a Garage Building is provided to the south for storage of trucks and vehicles used on the establishment, together with a garage workshop for servicing and repairs to this equipment and farm equipment.

Since the program of the Training School provides for certain duties to be performed by higher grade patients, both as occupational therapy and because they are valuable to the institution, certain areas have been equipped with all safety devices, and in order to provide necessary training facilities, are somewhat larger than would be required by normal working staff. These areas include the laundry, sewing room, woodworking shop and kitchen.

Sewer and water mains are connected to the city of Moose Jaw facilities. This necessitated three pumping stations and a large underground water reservoir on the site. A separate storm sewer is provided, emptying into Moose Jaw Creek. Heating is carried out from the central heating plant and distributed through the passageways and tunnels to the equipment rooms in the different buildings. Similarly, power distribution, telephone intercommunication and so forth is distributed through the tunnels to all buildings on the establishment. The establishment is adequately lighted by standards fed from underground cables. All electric wiring is, therefore, run through tunnels or underground. Roads are now gravelled, but they will be hard surfaced within the next year or two. Temporary tree nursery has been set up and landscaping will get underway later this fall or early next spring.

Main access to the establishment is over a new road and a bridge south of the city of Moose Jaw.

All buildings are of modern design, and buff rough-textured face brick is used. Exterior wood trim, including sash, varies in color throughout the institution. Each cottage has a separate color which ties in with cloakrooms in the dining building. The interiors of all buildings have specially designed color schemes. Strong violent colors are avoided and colors vary throughout each building. Floor, wall and ceiling treatments are integrated into a pleasing overall effect.

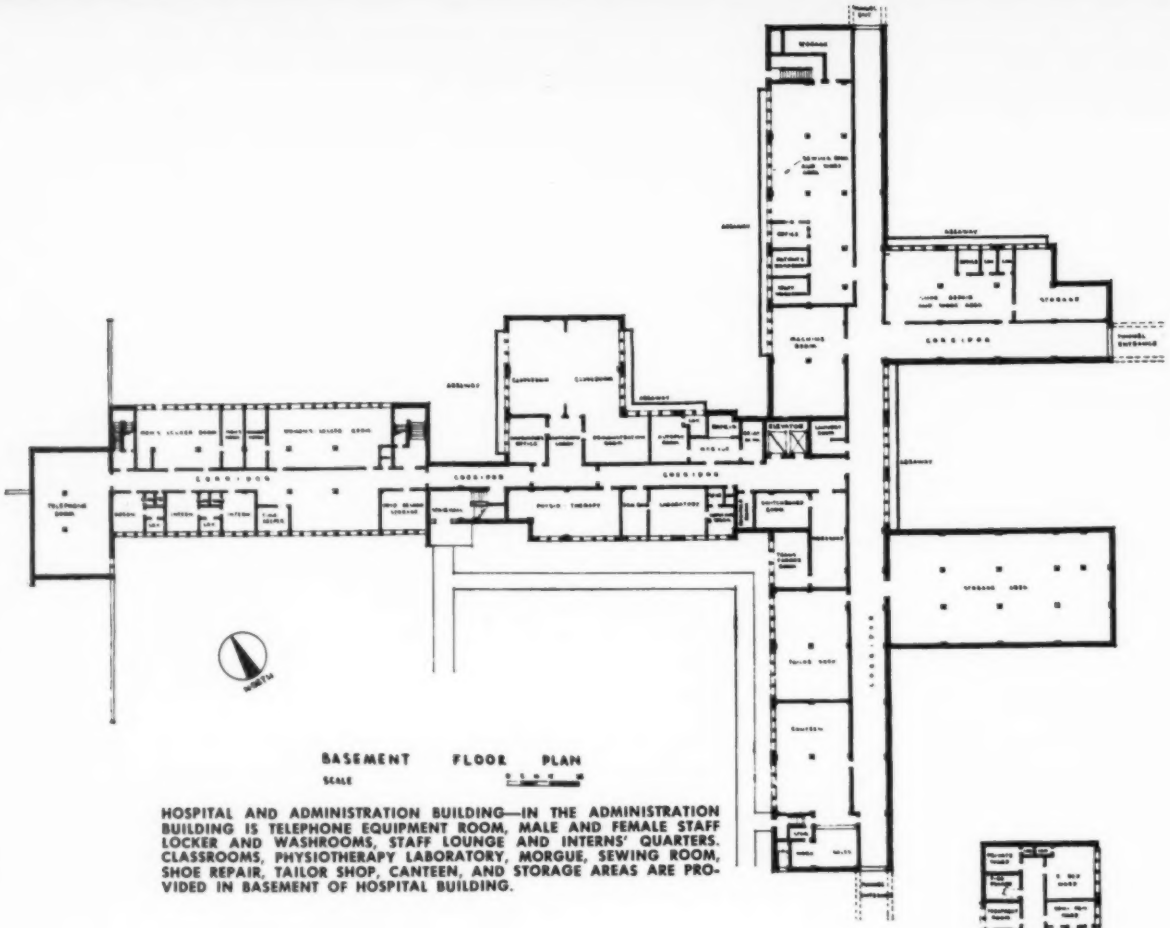
Agricultural Facilities Planned

Future plans provide for eight additional low grade units, chapel, canteen, incinerator, root cellar and greenhouses, and farm buildings for patient training, together with completion of paved roads and landscaping. The basic industry of the Province of Saskatchewan is agriculture. It is considered that agricultural experience will assist substantially in the rehabilitation of higher grade patients who wish to return to their farms. Landscaping and maintenance of grounds will be carried out to a considerable extent by the patients. Provision is also made on the drawings for block terraces and so on, to be built by patient help at some future date.

An article about the program at the school is in course of preparation and will be published in the near future together with plans and photographs of other facilities of the school.

Dormitory in low-grade building

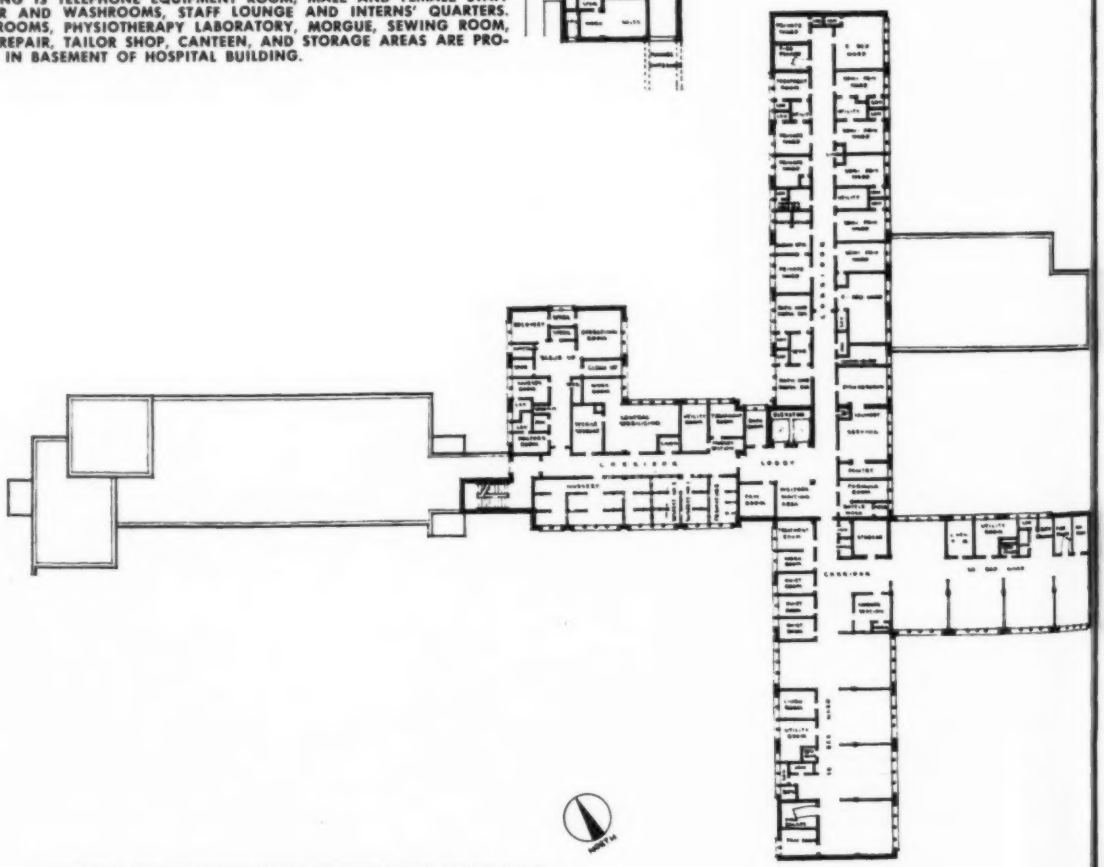
Dormitory in high-grade building



BASEMENT FLOOR PLAN

SCALE

HOSPITAL AND ADMINISTRATION BUILDING—IN THE ADMINISTRATION BUILDING IS TELEPHONE EQUIPMENT ROOM, MALE AND FEMALE STAFF LOCKER AND WASHROOMS, STAFF LOUNGE AND INTERNS' QUARTERS. CLASSROOMS, PHYSIOTHERAPY LABORATORY, MORGUE, SEWING ROOM, SHOE REPAIR, TAILOR SHOP, CANTEEN, AND STORAGE AREAS ARE PROVIDED IN BASEMENT OF HOSPITAL BUILDING.



HOSPITAL AND ADMINISTRATION BUILDING—OPERATING SUITE, CENTRAL STERILIZING, NURSERY, ISOLATION WARDS AND WARD AREAS ARE SHOWN.

SECOND FLOOR PLAN

SCALE

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